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**Alert**

Even though the COVID pandemic has essentially locked down most Americans, the work of O&P practitioners continues to be essential. We serve every patient population, from infants to the elderly in many locations, including hospitals, nursing homes, and of course our own facilities. This care simply cannot stop because of the spread of COVID-19.

Despite the critical care and professional expertise O&P provides, there remains a widespread perception that O&P is simply a subset of Durable Medical Equipment (DME). The perception that O&P practitioners are the same as DME suppliers continues to negatively impact the profession and more importantly, patients. This pandemic has made the need for Congress to statutorily distinguish O&P from DME even clearer given the essential care O&P practitioners are providing. Please write your legislators on the importance of this issue by filling in your information to the right. You are strongly encouraged to personalize this message with your own stories of the care you’re providing, and the experiences you’ve had as a practitioner since the start of the pandemic.

**More Information**

Section 2(a) of the Medicare Orthotics and Prosthetics Patient-Centered Care Act (H.R. 5262), introduced by Reps. Mike Thompson (D-CA), GT Thompson (R-PA), GK Butterfield (D-NC), and Brett Guthrie (R-KY), would distinguish orthotists and prosthetists from suppliers of DME and supplies, thereby aiming to protect patients by differentiating the clinical, service-oriented manner in which orthoses and limb prostheses are provided in contrast to the commodity-based nature of DME.

Specifically, this language would:

* Remove the term “orthotics and prosthetics” from the definition of “medical equipment and supplies”
* Codify separate statutory requirements for O&P practitioners and suppliers.

COVID-19 puts our practitioners in danger as they interact with patients:

* Fitting of TLSO (Thoracic Lumbar Sacral Orthosis) on COVID patients. A TLSO is typically a two-piece clamshell design that extends from just below the collar bones down to the pelvis and can be used on COVID patients to assist with breathing.
* Adjustment of cranial helmets for infants and children. These are vital to the patient and cannot be put off as the timely delivery is critical to the rehabilitative intervention.
* Ensuring seamless delivery of patient rehabilitation, which is critical to patient recovery; a patient who misses their rehab appointments suffers additional comorbidities and longer treatment times.
* COVID has been linked to an increased prevalence of blood clots and thrombotic events, some of which [have led to amputations](https://www.scmp.com/news/world/article/3081869/doctors-amputated-actors-leg-whats-coronavirus-link).
* Finally, separation would open avenues for O&P practitioners to bill for telehealth. Being tied to DME means our practitioners bill for items, not for services; while our practitioners are expanding their use of telehealth exponentially during COVID, they are unable to bill for these services. Separation is a critical first step to make this happen.

Clearly, the fearless work being done by O&P practitioners is much more than delivery of medical equipment. Medicare beneficiaries would greatly benefit from recognition of the care we provide, not only the medical devices being used for clinical intervention.

It’s important to note that separation would protect patients and *does not create a new Medicare benefit.* The change would not increase Medicare services, reimbursement, or the volume of patients seen. Therefore, there should be no cost to create this separation.

Please write your members of Congress TODAY and urge them to include language to statutorily separate O&P from DME in the next COVID bill. Simply enter your information to the right to get started. Your advocacy efforts are greatly appreciated!

**Link to act** [**http://aopavotes.org/**](http://aopavotes.org/)**.**

**Message to Congress**

I’m writing to request that you include language in the next package of COVID legislation that would statutorily separate orthotics and prosthetics (O&P) from durable medical equipment (DME).

While the O&P community is working hard to ensure practitioner and patient safety during the pandemic, O&P’s critical work must continue. We serve every patient population, from infants to the elderly in many locations, including hospitals, nursing homes, and of course our own facilities.

However, despite the critical care and professional expertise orthotists and prosthetists provide, the perception that O&P practitioners are the same as DME suppliers continues to negatively impact the profession and more importantly, patients. During this pandemic, it makes sense for Congress to statutorily distinguish O&P from DME because of the essential care O&P practitioners are providing.

Examples of this care include:

* Fitting of TLSO (Thoracic Lumbar Sacral Orthosis) on COVID patients. A TLSO is typically a two-piece clamshell design that extends from just below the collar bones down to the pelvis and can be used on COVID patients to assist with breathing.
* Adjustment of cranial helmets for infants and children. These are vital to the patient and cannot be put off as the timely delivery is critical to the rehabilitative intervention.
* COVID has been linked to an increased prevalence of blood clots and thrombotic events, some of which [have led to amputations](https://www.scmp.com/news/world/article/3081869/doctors-amputated-actors-leg-whats-coronavirus-link). We can’t ask new amputees to wait for their prosthetic until the pandemic subsides.
* Finally, separation would open avenues for O&P practitioners to increase their use of telehealth. Being tied to DME means our practitioners bill for items, not for services; while our practitioners are expanding their use of telehealth exponentially during COVID, we are unable to bill for these services. Separation is a critical first step to make this happen.

Section 2(a) of the bipartisan Medicare Orthotics and Prosthetics Patient-Centered Care Act (H.R. 5262) would distinguish orthotists and prosthetists from suppliers of DME and supplies, thereby aiming to protect patients by differentiating the clinical, service-oriented manner in which orthoses and limb prostheses are provided in contrast to the commodity-based nature of DME.

Specifically, this language would remove the term “orthotics and prosthetics” from the definition of “medical equipment and supplies” and codify separate statutory requirements for O&P practitioners and suppliers. Importantly, separation would protect patients and *does not create a new Medicare benefit.* The change would not increase Medicare services, reimbursement, or the volume of patients seen. Therefore, there would be no cost to create this separation.

Clearly, the fearless work being done by our practitioners is much more than delivery of medical equipment. Medicare beneficiaries would greatly benefit from recognition of the care we provide, not only the medical devices being used for clinical intervention. I appreciate your consideration of adding section 2(a) of H.R. 5262 to the next package of COVID legislation.